

18 Months Old**AHCCCS EPSDT Tracking Form**

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship	

NICU: <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS : <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS Pathway:	Allergies:				Temp:	Pulse:	Resp:	
Risk indicators of hearing loss: <input type="checkbox"/> yes <input type="checkbox"/> no	Medications:	Birth Wt:	Wt:	%	Length:	%	Head circ:	%		

PARENTAL CONCERNS/HISTORY:

VERBAL LEAD RISK ASSESSMENT: ☒ INDICATES GUIDANCE GIVEN: At risk ☐ yes ☐ no

DENTAL SCREEN: ☒ INDICATES GUIDANCE GIVEN: ☐ Brushing daily ☐ 1st Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: ☒ INDICATES GUIDANCE GIVEN: ☐ Breast fed/whole milk ☐ Feeds self ☐ Nutritionally balanced diet
☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements _____
☐ Solids

DEVELOPMENTAL SCREEN: ☒ INDICATES ACCOMPLISHMENTS ☐ Uses a cup ☐ Walks ☐ Says 10-20 words ☐ Says "No" ☐ Name one picture/2 colors/
☐ Follows simple rules/bring me the book ☐ Knows animal sounds ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: ☒ INDICATES GUIDANCE GIVEN: ☐ Drowning prevention ☐ Emergency 911
☐ Discipline/limits ☐ Read to child ☐ Dental caries prevention ☐ Sibling interaction ☐ Nutrition/mealtimes ☐ Defiant behavior/offer child choices
☐ Never leave toddler alone ☐ Growing independence ☐ Encourage expression of wide range of emotions ☐ Other

BEHAVIORAL HEALTH SCREEN: ☒ INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family adjustment/parent responds positively to child
☐ Encourage holding ☐ Self calming ☐ Frustration/hitting/biting/impulse control ☐ Communication/language
☐ Demonstrates increasing independence ☐ Begins to show defiant behavior ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED:	<input checked="" type="checkbox"/> INDICATES ORDERED <input type="checkbox"/> TB skin test (if at risk) <input type="checkbox"/> Other <input type="checkbox"/>
IMMUNIZATIONS:	<input checked="" type="checkbox"/> INDICATES ORDERED <input type="checkbox"/> Pt. Needs immunization today <input type="checkbox"/> Delayed/Deferred <input type="checkbox"/> Parent refuses <input type="checkbox"/> Other reason <input type="checkbox"/> History of chicken pox <input type="checkbox"/> HepA <input type="checkbox"/> HepB <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> DTaP <input type="checkbox"/> Hib <input type="checkbox"/> IPV <input type="checkbox"/> PCV <input type="checkbox"/> Influenza <input type="checkbox"/> Other
REFERRALS:	<input checked="" type="checkbox"/> INDICATES REFERRED <input type="checkbox"/> CRS <input type="checkbox"/> WIC <input type="checkbox"/> ALTCS <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Audiology <input type="checkbox"/> Speech <input type="checkbox"/> AzEIP/DDD <input type="checkbox"/> Developmental <input type="checkbox"/> Behavioral <input type="checkbox"/> Dental <input type="checkbox"/> Early Head Start <input type="checkbox"/> Specialty <input type="checkbox"/> Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐ Yes ☐ No